the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE

FALL, 1957

OBSESSIVE-COMPULSIVE NEUROSIS - PAGE 76

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The Cover

The compulsive hand-washer is a classic example of the obsessive compulsive neurosis. This was graphically portrayed in the character of Lady Macbeth, who, like the compulsive neurotic, vainly attempted to rid herself of the sense of guilt through the ritual of repeated hand-washing. Compulsive counting and obsessional fixation on a meaningless phrase or sentence are other examples of obsessive defensive mechanisms which are, in a sense, a magical means of protecting the individual from unwanted or unacceptable, unconscious feelings. A discussion of this subject begins on page 76.
The cover drawing was executed by Mr. Joseph F. Schwarting.

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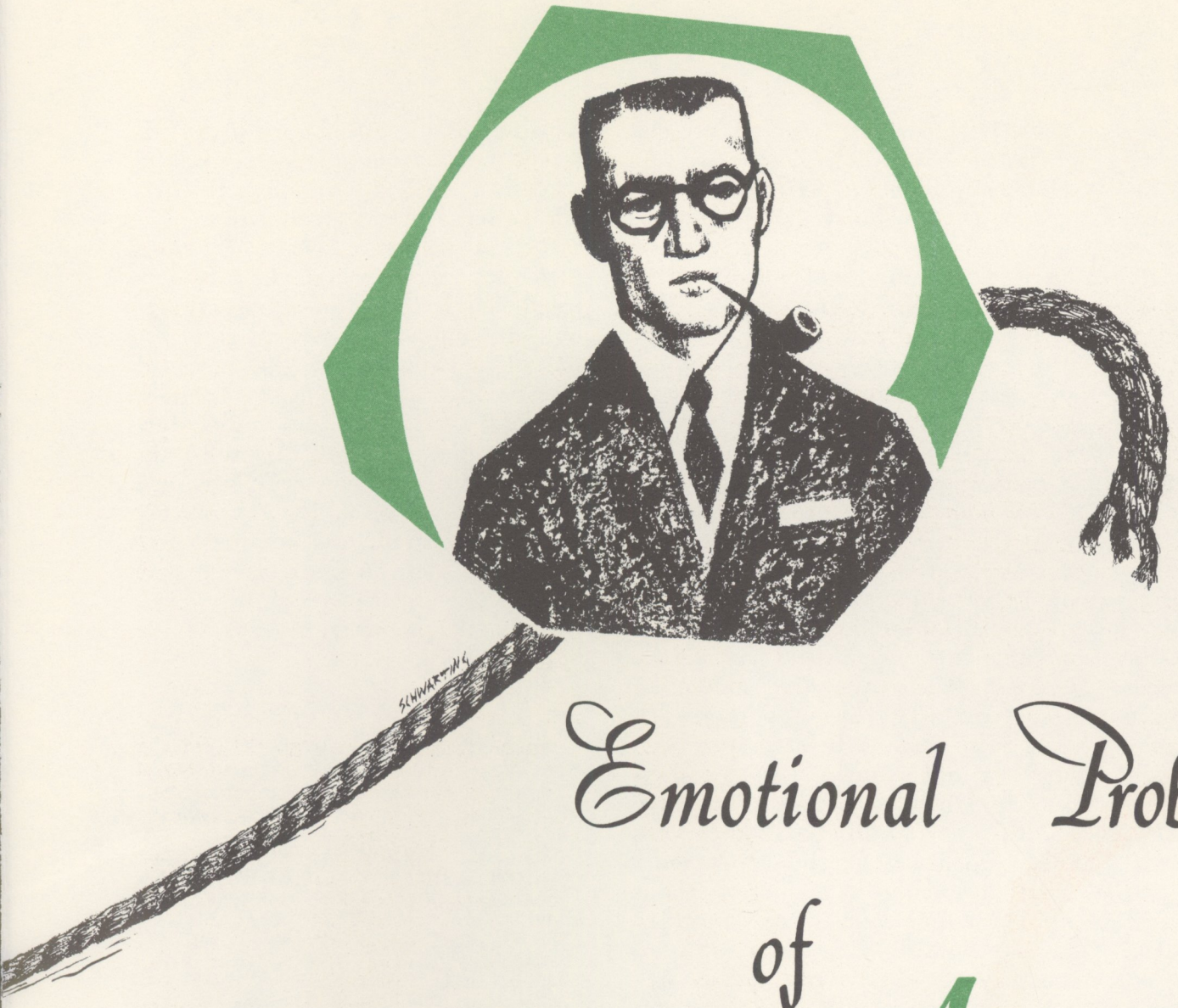
THE EDITORS

CONTENTS

TO MANY INDIVIDUALS adolescence is one of the most difficult periods of life. Anna Freud described children at this stage, as " . . . excessively egoistic, regarding themselves as the centre of the universe . . . and yet at no time in later life . . . capable of so much self-sacrifice and devotion. . . . They oscillate between blind submission to some self-chosen leader and defiant rebellion against any and every authority. They are selfish and materially-minded and at the same time full of lofty idealism. They are ascetic but will suddenly plunge into instinctive indulgence of the most primitive character." Ideally, during this period, the personality develops from the complete dependency of childhood to adult independence. At this time the adolescent strives for a new behavior pattern that will acceptably integrate the opposing forces of internal drives, external reality, and conscience. Adaptive patterns that were formerly successful become unacceptable for new conflicts as well as for the recurrent anxieties of earlier childhood.

Severe psychiatric disorders among adolescents are uncommon. According to the 1957 report of the National Committee Against Mental Illness, psychotic disorders seldom occur before the age of 15. Less than one per cent of patients newly admitted to state mental hospitals each year are under 15 years of age; approximately 16 per cent are between 15 and 29 years of age. More often, lack of successful adaptive behavior is indicated by psychosomatic symptoms, delinquency, failure in school, or neurotic manifestations. Adolescent disturbances differ from adult neuroses in that they frequently appear disproportionately severe and exhibit bewildering and rapidly changing sets of symptoms. Adolescents are more malleable than adults, and usually respond more quickly to treatment.

From observation of emotionally disturbed patients, it is apparent that one of the basic areas of conflict is that of the parent-child relationship. In adult life neuroses are complicated



Emotional Problems of Adolescence

by strictly adult conflicts, but in adolescence the correlation between disturbance and the parental relationship is particularly obvious. Earlier, the need for love as well as for physical care had brought about denial of hostility toward parents. At this age, although the longing to be loved is as strong as ever, the defense mechanism is no longer valid. The good-natured, submissive child seems to turn into a hostile, quarrelsome adolescent. Rebellion is often expressed in the form of aggressive behavior, such as drinking, driving a car too fast, or, in lesser forms, by rudeness or door slamming.

In confused and vacillating attempts to achieve adult personality, the adolescent is often further hampered by unhealthy parental attitudes. Parents with rigid demands, or those who set too-high standards for their children are as anxiety-producing as parents who afford complete independence. For example, choice of vocation may be the occasion for conflict with parents. Lack of father-son occupational identity may make the choice of vocation difficult for boys, and, according to Josselyn, the son who is discouraged from following his father's trade and is encouraged to better himself may suffer anxiety from fear of failure.

Another important area of conflict results from the physical changes of adolescence. The well-known awkwardness of adolescence does not so much result from a lack of ability to co-ordinate as from increased self-consciousness. As a child the individual forms a concept of his body which he relates to his surroundings and which suffices until adolescence. With the rapid growth of puberty, however, body image and identity must be revised in terms of physiological change, greater awareness, and altered values. Height, weight, and degree of growth assume exaggerated importance, and the almost universal wish for conformity in appearance is evidenced. Since such deviations as small stature in a boy or overweight in a girl may become significant to the extent of considerable emotional distress, specific reassurance should be given. Early fears of dismemberment are reactivated in which the integrity of the body is seemingly threatened. The great variation in degree of maturation among adolescents is often overlooked. To expect the same progression in all children in a particular group is both illogical and often unrewarding. Hand-wrist x-rays of groups of children of the same chronological age may show differences of several years in skeletal ages. Most adolescents are able to accomplish emotional and perceptional adaptation to body change but those who continue to evidence confusion and

anxiety will need assistance.

Probably it is the adolescent's awareness of outward changes in his own body and in the bodies of others as well as his glandular changes that accounts for increased concern with sex. Adolescents become fearful of the effect of masturbation or of sexual promiscuity on mental and physical well-being, and, in addition, earlier sexual conflicts are reactivated. Oedipal feelings repressed in childhood are reactivated, but the formerly successful adaptive behavior of identification with the parent of the same sex is no longer valid. In adolescence it amounts to a denial of the desire for independence. In abandoning parental identification, and with individual personality still unformed, the adolescent must look elsewhere for identification. Since sexual needs involve emotional as well as biological factors (the need to be loved, to be accepted, and to achieve self-respect), the adolescent frequently seeks identification with a gang, an idealized individual, or with political or religious groups as sources of the ego-strength that he requires.

In addition to altered ego-identity and loss of self-confidence, in adolescence individual perception of the outside world is increased. The judgments formed in childhood are no longer adequate, and adult duplicity becames painfully obvious. A child may find differing sets of values in home, school, church, and business, and may react with as much dismay over governmental corruption as he does to curtailment of personal privilege. One of the most disturbing factors to the adolescent's mind is establishment of the point at which he is expected to think and judge for himself. In our culture, there are few ceremonies or symbolic rites to mark the achievement of adult status. During childhood, the individual obviously does not have full responsibility for his behavior. As he grows older, he has more freedom in self-government but is still limited. At adolescence, he is expected to assume greater responsibility and is encouraged to take his place as a part of society; yet the total privileges of adult status are withheld. Without knowledge and experience, and with little self-confidence, the adolescent still demands complete privileges and responsibility although he fears them.

Difficulty in adjustment to conflict is readily evident in the adolescent's performance in school. Such maladjustments as scholastic failure or truancy may be the result of deficient intelligence, physical disorder, or of specific disabilities, such as reading impairment. Emotional problems, however, constitute the source of many problems of adaptation. In boys with high scholastic potential but low achievement, investigation by Kimball showed lack of positive identification with the father and close attachment to and dependency upon the mother. The boys under study seldom expressed hostility openly. Failure was not a result of inability but simply of apathy. Apparently, less anxiety is accrued by failure because of lack of effort than by attempting success with the risk of possible failure.

With these emotional problems, how does the adolescent achieve maturity? In some instances, psychological maturity is never reached. The defenses adapted as ego-protection against the multiple pressures of adolescence may become fixed in the regressive patterns of childhood. While it is true that many adult neuroses originate during childhood, it is equally apparent that the period of adolescence may also provide an origin. Adolescence, however, offers an opportunity for resolution not only of present conflicts but a "second chance" at resolution of the conflicts of childhood as well. The unsolved problems of adolescence become the neuroses of the adult, and in an attempt to satisfy emotional needs, the adolescent will experiment with various patterns of integration that may result in behavior which at times seems far from normal. In considering the adolescent who exhibits symptoms of emotional distress, it is essential to understand the basis of his striving. In most cases, though, the adolescent adaptation to the adult world is accomplished in well-integrated fashion. Love and guidance are essential in order for any adolescent to regain his self-identity, not as an imitation of another, but as a person able to utilize his fullest potentials within the framework of his individual limitations.

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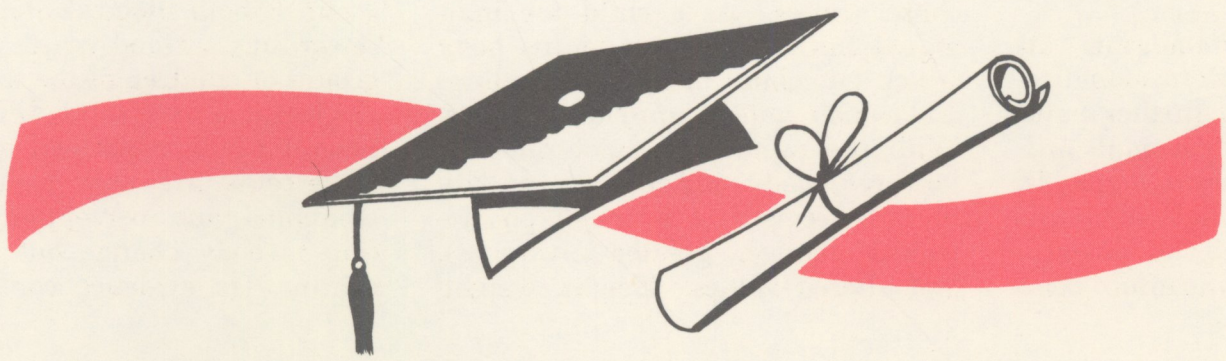

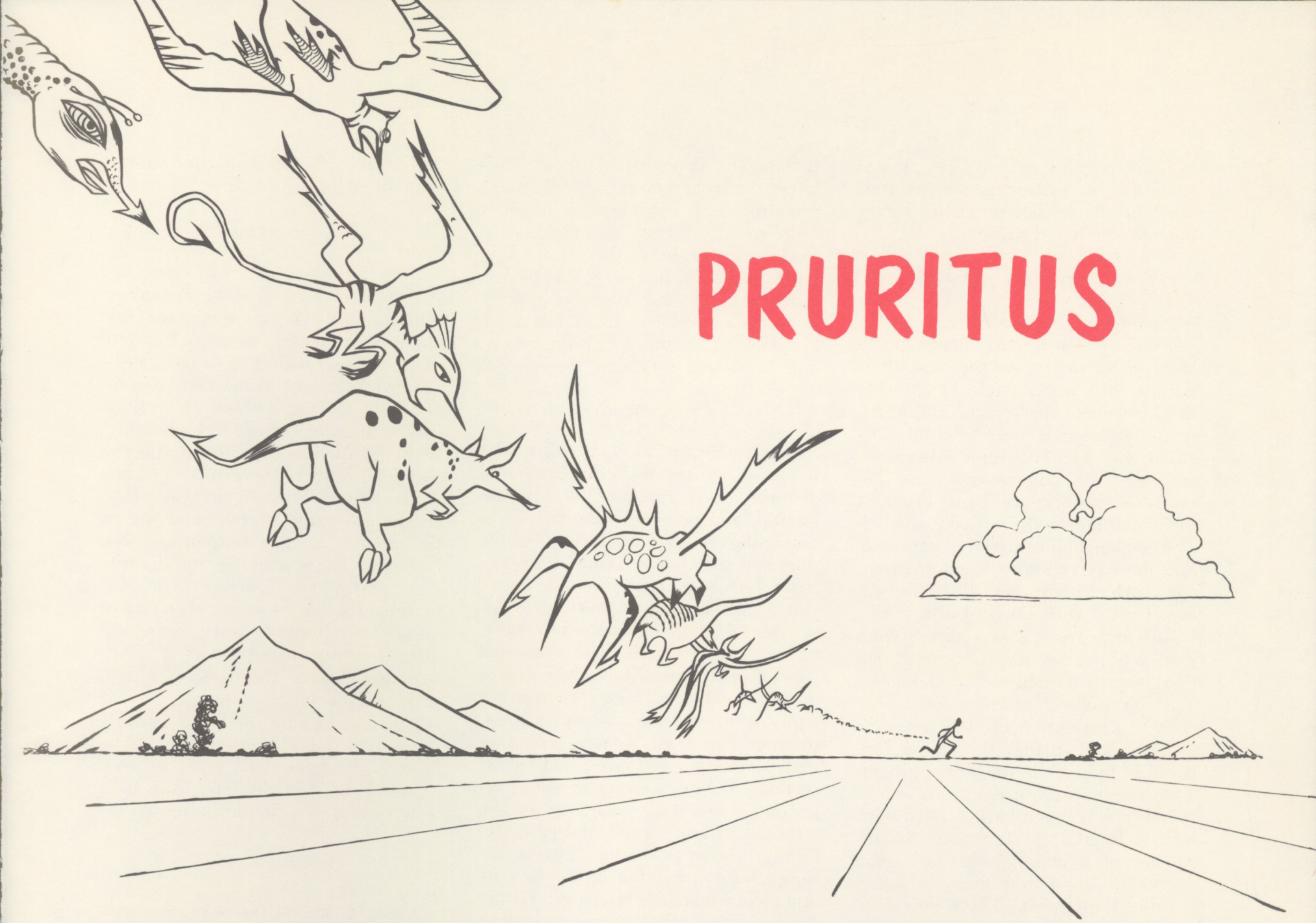

PRURITUS

PRURITUS is a subjective symptom that can be indicative of many disorders and can also exist when no organic disease or other etiologic factor is demonstrable. In the opinion of some investigators the term really should be used only when no organic change is evident. The discomfort of itching is too well known historically and medically to require descriptions. It is also a commonplace that if such discomfort is protracted it can have a specific effect upon a patient's emotional status. Pruritic disorders can have emotional origins or can be exacerbated by nervous tensions.

Hecht illustrates the tremendous personal value assigned to the skin by the amounts of money that are spent upon cosmetics and sunlamps. He also comments that the skin does literally communicate, arouse, receive, and convey emotions. In the itch-scratch reflex both emotional cause and effect are demonstrated. Some amount of erotization does, seemingly, result from scratching, and aggressive or hostile impulses may be discharged in this manner.

Psychogenic causation of skin disease is by no means always implicit. In the absence of obvious organic disorder, however, there is the fact to be considered that the autonomic nervous system does directly influence the skin, and the autonomic nervous system is related to or affected by the intellectual processes. Feeble-minded patients are not usually troubled with functional dermatoses, and functional skin diseases do not occur at all in animals.

Pruritus may be localized or generalized, is frequently intractable, and may result from innumerable physiologic and pathologic causes. Idiopathic pruritus is rarely an "only" symptom. Usually a variety of complaints exists. Of localized pruritus, Sulzberger says that even if emotional factors are not causative they may incite, aggravate, and prolong the disorder. According to Hecht, "Even in the presence of organic etiologic agents, emotions may act upon tissue barriers so as to produce variations of illness from sub-threshold states to the most acute." Actually, emotional stresses are known to be important in the etiology of functional pruritus of the genital, anal, and oral areas. Some authorities consider this true of the aural regions also. Pruritus vulvae and ani are examples of skin disorders that are difficult to ameliorate and often are obscure as to causation.

Obviously, establishment of the cause of itching is of immediate importance, as pruritus may be symptomatic of diabetes, Hodgkin's disease, and of some of the blood dyscrasias. Among the more frequently discovered causes are parasitic infestations, fungi, contact dermatitis, drug intoxication, jaundice, and some of the deficiency states. Fecal matter, urine, or vaginal secretions may irritate the perianal skin, as may cleansing agents, friction, or congestion. Allergic reactions to extraneous irritants may be mild, but anxiety, tension, or fatigue can intensify the symptoms. It is possible, according to Waldbott,

to misconstrue a patient's reaction to pruritus. A conspicuously nervous reaction should not necessarily connote an emotional cause.

Contributory factors

Among the influences that predispose to pruritus ani investigators have listed worry, hysteric manifestations, overwork, fright, masturbation, chronic alcoholism, insomnia, sexual repression, and sedentary occupations. The syndrome is often associated with constipation, and patients seemingly are more often of the rigid personality types. Associated melancholia, anxiety, paranoia, and depressive states are sometimes cited. Men, more often than women, are affected with pruritus ani.

Vulvar pruritus is exceedingly common and occurs more often in patients who are middle-aged and older. The physiologic changes of aging, such as diminution of estrogen, skin atrophy, and shrinkage of tissue, are possible factors in the development. The symptom requires careful attention as it is frequently associated with serious organic dysfunction. In instances of functional disease, some degree of emotional maladjustment is usually manifest. There may be a connotation of guilt or fear, a repugnance toward sexuality or femininity, or unrecognized masochistic tendencies may exist.

Symptomatic therapy

Whether the pruritus is idiopathic or otherwise, the initial efforts of the physician are directed toward making the patient more comfortable. Actually, no therapeutic procedure is wholly successful. Removal of mechanical irritants, careful cleansing procedures, and recommendations of soft loose clothing are obvious means. Wet compresses, avoidance of strenuous exercise, and dietary alterations are sometimes helpful, even if only psychologically. Topical therapy must be judiciously chosen because of possible allergens, and many ointments and dusting powders afford media for bacterial growth or for further aggravation of existing lesions. Hormonal therapy is utilized in some instances; local anesthesia is often used; and surgery and irradiation have been employed. Even in intractable pruritus, though, these have the concomitant disadvantage sometimes of making the disorder more specifically relevant to the area. Waldbott reminds therapists that with all means, however, it is important that the patient's emotional equilibrium be restored or maintained. Frequently, vitamin B preparations and mild sedatives may be needed.

Psychotherapy

Psychotherapy may be efficacious in instances in which the emotional disturbance is apparent, is environmental, and is recent. Patients with newly-developed symptoms whose previous social and familial adjustment has been good are the better suited to supportive psychiatric assistance. In a series reported by Wittkower, 74 patients were treated psychotherapeutically for four skin disorders. The ailments chosen for study were eczema, pruritus vulvae, pruritus ani, and rosacea, since in each an emotional origin could be discerned. Treatment was arranged on an outpatient basis and most of the patients were seen individually. Group therapy sessions were attempted for only a few of the patients and electroshock for only two. Of the total number, some degree of benefit was detectable in 60. Three months later, on follow-up investigations, 35 patients were found to be still improved or further improved, and 17 had regressed. The patients with pruritus ani responded least, those with rosacea the best.

Silverman comments both upon the poor prognosis in pruritus vulvae and ani and upon the exceptional cases who do respond well. In an instance that he cited, the patient was 54 years old, male, and referred from a genitourinary services clinic. The patient had been to several physicians because of persistent itching in the anal region and had been receiving prostatic massage. He had been temporarily impotent, and his pruritic discomfort was increased by his wife's attitudes and comment. Brief psychotherapy was utilized, and in the first three interviews the patient was able to express his anger at his wife. After such ventilation the patient regained potency, after which the itching disorder abated. Six months after therapy he reported maintenance of improvement and again after another equivalent period of time.

Conclusion

Skin disorders that are emotional in origin or that are aggravated by tensions have been recognized and studied for many years. A hundred years ago, according to Allison, Erasmus Wilson was recommending diversions or "agreeable occupation" in instances of pruritus. Unhappily, with the increased understanding of such discomforts there has not been equivalent progress in therapy. Psychotherapy may afford the means of treatment that has heretofore been lacking. There can be no definite statement of curability or lack of it in the pruritic disorders. Silverman says, "Psychiatrist and dermatologist, working together in a well-designed clinical and basic investigation, will do much to accelerate our acquisition of knowledge regarding the skin in sickness and health." The family physician will wish to keep in mind the contributions from both in appraisal of pruritic patients.

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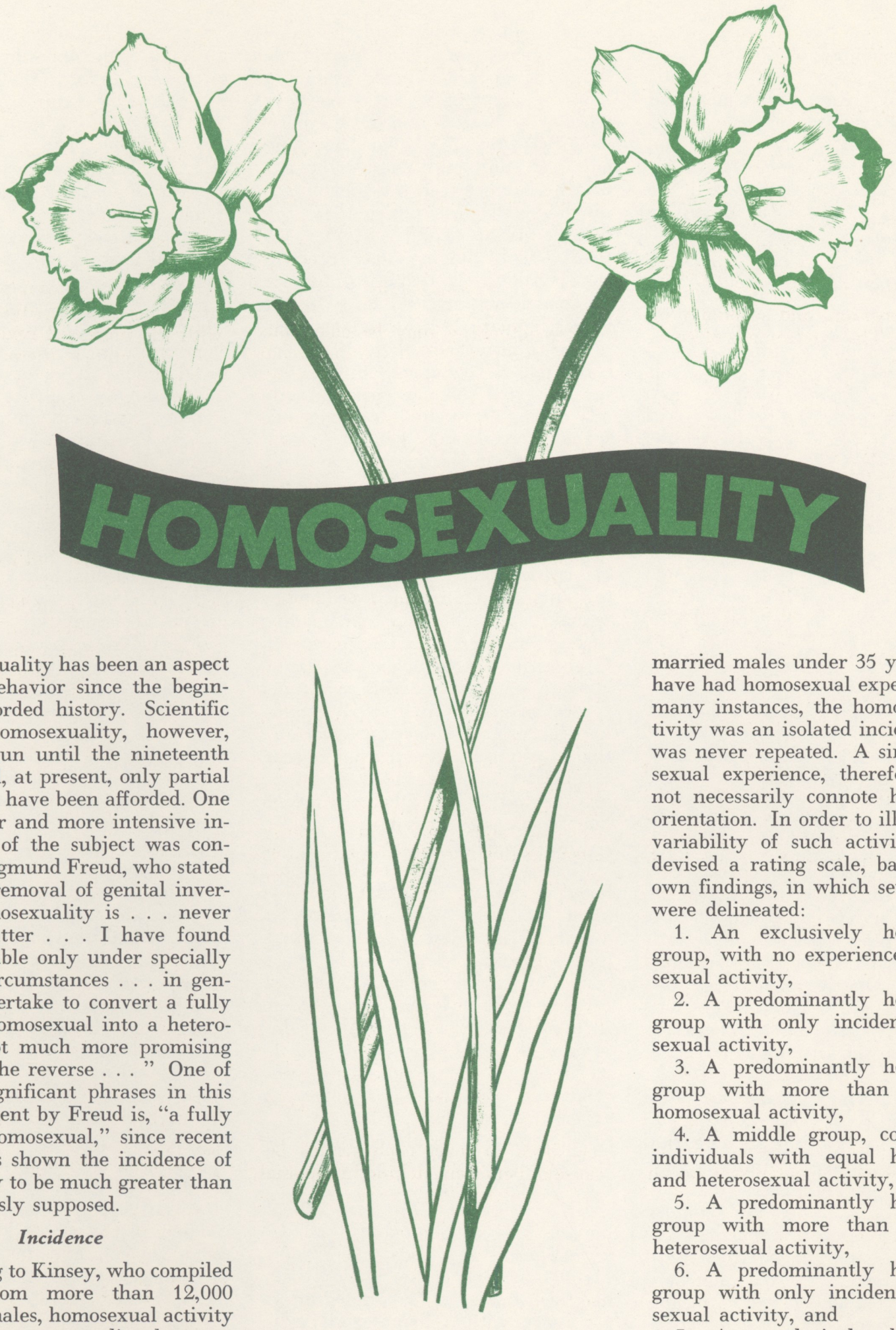

● Homosexuality has been an aspect of human behavior since the beginning of recorded history. Scientific study of homosexuality, however, was not begun until the nineteenth century, and, at present, only partial explanations have been afforded. One of the earlier and more intensive investigations of the subject was conducted by Sigmund Freud, who stated that, "The removal of genital inversion or homosexuality is . . . never an easy matter . . . I have found success possible only under specially favorable circumstances . . . in general, to undertake to convert a fully developed homosexual into a heterosexual is not much more promising than to do the reverse . . . " One of the most significant phrases in this pronouncement by Freud is, "a fully developed homosexual," since recent research has shown the incidence of such activity to be much greater than was previously supposed.

Incidence

According to Kinsey, who compiled statistics from more than 12,000 American males, homosexual activity is not a rare or sporadic phenomenon. This investigator found instead that one male in every three has experienced homosexual activity, and approximately 50 per cent of unmarried males under 35 years of age have had homosexual experiences. In many instances, the homosexual activity was an isolated incident which was never repeated. A single homosexual experience, therefore, would not necessarily connote homosexual orientation. In order to illustrate the variability of such activity, Kinsey devised a rating scale, based on his own findings, in which seven groups were delineated:

1. An exclusively heterosexual group, with no experience of homosexual activity,
2. A predominantly heterosexual group with only incidental homosexual activity,
3. A predominantly heterosexual group with more than incidental homosexual activity,
4. A middle group, composed of individuals with equal homosexual and heterosexual activity,
5. A predominantly homosexual group with more than incidental heterosexual activity,
6. A predominantly homosexual group with only incidental heterosexual activity, and
7. An exclusively homosexual group.

The material for *Sexual Behavior in the Human Male* included personal histories of individuals from

large cities, small towns, rural areas, colleges, religious institutions, and other population groups. The results showed that histories of homosexual activity occurred in every age, social, intellectual, and occupational group. The variability of homosexual behavior, therefore, makes apparent the need for an inclusive and definitive description of the term.

Definition of homosexuality

Sexual behavior may be considered both in terms of the aim or type of activity, and the object or person toward whom the activity is directed. The term *homosexuality* has reference only to the *object* or person involved. Hence, by definition, any type of sexual activity performed with a person of the *same* sex is homosexual. Conversely, any sexual activity performed with a person of the opposite sex is heterosexual, regardless of whether the type of activity may be considered "normal" by other standards of behavior. The direction of sexual impulses toward persons of the same sex may be predominant but unrecognized. For the individual who is unaware of latent homosexual tendencies, marriage may precipitate intense emotional conflict.

Etiologic factors

In general, there have been two conflicting theories of the etiology of homosexuality. One predicates a constitutional basis, either in direct genetic inheritance or in hormonal imbalance, whereas, according to the alternate theory, psychological factors are considered determinant. Familial studies have shown no corroborative evidence for a hereditary basis. Although a child may emulate an adult with whom he is closely associated, homosexuality as a transmissible trait has not been proved. Similarly, the hormonal imbalance theory has not been established. Many investigators have believed endocrine imbalance to be of etiologic importance, since some male homosexuals show a high percentage of female hormones in the blood, and some female homosexuals a high percentage of male hormones. An abnormal androgen-estrogen ratio cannot yet be proved to be of critical significance, because many homosexuals do not show similar imbalances; many heterosexuals do show such imbalances; and individuals may change from heterosexual to homosexual activity, or, conversely, without any alteration in hormone balance. Obviously, then, hormone administration may change the endocrine balance of a homosexual individual but will not modify the direction of his sexual behavior. Actually, such therapy may produce the opposite effect, that of stimulation of sexual activity, which will, of course, remain homosexual activity.

According to most theories of psychosexual development, differentiation of sexual behavior occurs gradually during early childhood. Normal sexual development, with the probable occurrence of masturbation and even possible homosexual incidents, culminates, eventually, in heterosexual orientation and behavior. For heterosexual development, proper social encouragement is requisite, since, in societies that have sanctioned homosexuality, sexuality has been readily diverted to homosexual patterns.

Thus, most psychologic theories of etiology of homosexuality are concerned primarily with early childhood experience. There are, accordingly, several major experiences that are believed to be conditioning factors toward homosexual instead of heterosexual development.

1. *Early homosexual experiences or associations.* Seduction in early childhood before psychosexual development is completed is often cited. In a study of 79 homosexuals, East found that early seduction was the most common environmental factor. Other investigators, however, contend that such early experiences could not determine the total direction of sexuality unless such experiences were reinforced by subsequent satisfying experiences, or unless such activity satisfied some especial need for security and acceptance as well as for sexual satisfaction.

In a study of 10 reform school homosexuals as compared with 10 normal inmates, Greco and Wright found that each of the homosexuals had been intimately associated at an early age with a homosexual individual who had represented a source of comfort when the subject was under extreme emotional duress.

2. *Rearing of children as members of the opposite sex.* Such occurrences are extreme and fairly rare, although attitudes of the opposite sex are more often encouraged in less obvious ways than by costume or hair styles.

3. *Over-identification with the parent of the opposite sex.* For example, after the death of one parent, a child often emulates the remaining parent's demeanor and attitudes. Subsequent homosexual experiences may then serve to fixate latent tendencies.

4. *Protracted deprivation of heterosexual activity.* In circumstances in which the sexes are segregated, such as dormitories, prisons, and military installations, homosexual behavior may become a substitute outlet, referred to as "accidental homosexuality" by Fenichel. Even when opportunity for heterosexual activity is restored, however, some individuals cannot resume heterosexual activity. Some individuals will remain predominantly heterosexual with sporadic homosexual behavior, while the majority will resume exclusively heterosexual activity.

5. *The Oedipus and castration complexes.* The concepts of castration fears and the Oedipus complex are basic to psychoanalytic theory of psychosexual development. The castration complex is considered universal and is closely associated with the Oedipus situation, since the way in which the castration complex is resolved determines, to a large extent, the resolution of the Oedipus complex. Actually, pregenital influences and fixations are emphasized in substantiation of both theses.

In psychosexual development, progression to the heterosexual phase includes an intermediate and normal homosexual stage, characterized by segregation of the sexes in social and recreational pursuits. This period of "herd" activity is brief and succeeds the earlier Oedipus situation. The child's fixation upon the parent of the opposite sex is combined with fairly intense narcissism, or self-love. If, however, a boy identifies with his mother, he has chosen himself as the sexual object, and thereafter seeks love-objects similar to his own maternal identification. Hence, homosexual love-objects resemble the subject's own person more than heterosexual objects do.

Some psychoanalysts regard homosexuality as the result of specific mechanisms of defense which facili-

tate repression of both the Oedipus and castration complexes. According to this theory, early fears of castration are intensified by observation of female genitalia or the discovery that the female does not have a penis. The threat of castration is so anxiety-producing that, according to Fenichel, the male seeks a "girl with a penis" as a sexual partner. The castration complex is also determinant in the psychosexual development of the female, since girls may feel inferior to boys, or may develop penis envy, fears of sexual violation, or other fears related to physical appearance.

Whatever theory of etiology is accepted, homosexuality is obviously the result of prolonged personality mal-development that begins in early childhood. Thus, homosexual traits are as crystallized as any other personality traits and are just as difficult to eradicate. Although many individuals have homosexual experiences, homosexuality becomes a permanent aspect of behavior only when such practices have a special significance in relation to conflict, anxiety, and total adaptation. The practices of a homosexual individual are interrelated with his total personality, his evaluation of himself and of other persons, and with other emotional attitudes and modes of behavior.

Treatment

Complete reorientation of the homosexual individual is difficult, involved, and almost always necessitates prolonged psychiatric therapy, usually psychoanalysis. Any hope of eradication of homosexuality is based on the possibility of a complete change in behavior patterns, and this requires two years or more of treatment. Even with intensive therapy, the number of successful "cures" has been relatively small. Such apparently negative aspects, however, do not preclude any effort toward helping a homosexual patient. The success of treatment will, of course, depend upon the patient's dissatisfaction with his sexual orientation and the intensity of his desire to change his behavior. Such patients often consult physicians for relief from psychosomatic ailments or after anxiety attacks. In many instances the patient is concerned about immediate dysfunction. The physician's responsibility, then, is not to attempt to "cure" the homosexuality, but to relieve the anxiety or physical discomfort. If the patient is satisfied with his mode of sexual adjustment and has no wish to change, it is unwise to insist that he do so unless he is dangerously predatory in behavior. If the patient suffers from sporadic guilt feelings and merely wishes to ventilate his problems, in many instances, he may be given sufficient insight into his motivation so that he can accept his sexual orientation with minimal conflict. Usually, the patient can be helped to avoid overtly indiscreet behavior that would result in exposure and social ostracism.

Most authorities agree that marriage is not a successful means of changing patterns of sexual behavior. In most instances, marriage precipitates intense emotional distress and is rarely successful since the basic psychodynamics remain unchanged.

A patient who has an "accidental" homosexual experience may be helped by psychotherapy. Such persons have not engaged in compulsive or exclusive homosexual activities, and the total adaptation pattern is usually not involved. Even so, explanation and adequate psychotherapy may be needed to reduce guilt and anxiety.

Summary

Homosexual activity, of different degrees, is common and occurs briefly during the lives of many persons. These practices often represent repressive patterns first manifested in early childhood. Although the causes are incompletely comprehended, it is known that homosexuality is not inherited, and does not result from hormonal imbalance. Since the total behavior pattern is involved, marriage does not change the patient's basic personality components and may only increase his conflicts. Hormone therapy is similarly ineffective since the basic problem remains unchanged. Complete eradication of homosexual behavior can only be achieved if the patient has a sincere and intense desire to change his behavior. Treatment is long and tedious and usually psychoanalysis is necessary. Successful management, however, can be effected by helping the individual adjust to his sexual orientation with minimal anxiety and conflict with social mores.

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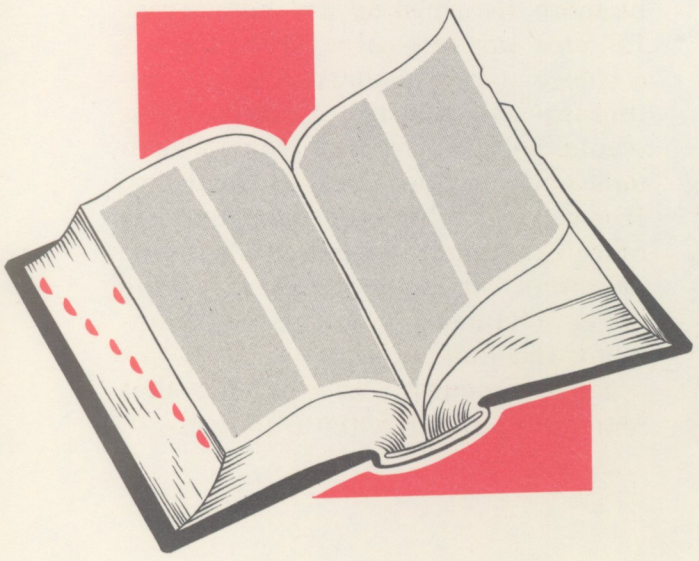

Glossary . . . . .

Psychotic depressive reaction is defined as a reaction in which the patient is severely depressed and may distort reality to the degree of hallucination and delusion. Two factors distinguish this reaction from manic depression, depressed type. Environmental conditions are frequently causative, and, in instances of psychotic depressive reaction, there is no history of previous depressions or of extremes in mood variation.

Diagnostic and Statistical Manual Mental Disorders, Washington, D.C., American Psychiatric Association Mental Hospital Services, 1952, p. 25.

IN PSYCHOANALYSIS AND PSYCHOTHERAPY similar therapeutic principles are utilized, although they differ, first, in results to be obtained, and, second, in the methods used. According to Viets, psychotherapy helps the patient to solve conscious or near-conscious problems by recognition and comprehension of the relationship between symptoms and conflicts. The therapist, then, by suggestion, helps the patient toward a more balanced and rational pattern of living. In psychoanalysis, the aim is not only that of individual adjustment. The purpose is more ambitious. Therapy is intended to resolve whatever neurosis prevents the patient's functioning at full capacity. By means of association, interpretation, and transference techniques, the psychoanalyst attempts to demonstrate to the patient the unconscious motivations and conflicts that have affected his emotional development.

In the psychoanalytic procedure, the patient is, by means of free association, encouraged to relive his past. In so doing, repressed childhood reactions to parental attitudes may be recognized. By transference, his familiar neurotic patterns may be redirected, initially against the analyst. Actually, simple re-experience is not enough. The crux of therapy is a matter of interpretation. The patient must necessarily interpret the neurosis with some degree of objectivity to become aware of the incongruity of his emotional patterns in his current life situation. Subsequently, the patient is able to overcome the childhood neurosis himself. If the emotional energy wasted upon maintenance of conflictive patterns of living is liberated, the patient is also enabled more nearly to realize his fullest potentialities.

Earlier investigators of Freudian concepts believed that regardless of symptoms the basic cause of maladjustment was sexual. It is becoming increasingly clear to analysts today that although basic conflicts are most vividly expressed in the sexual relationship, the pattern of gratification may be a brief summary of the entire life pattern but is not necessarily its determinant.

Not all emotionally disturbed patients are logical candidates for psychoanalysis. In instances of active psychoses or organic brain disease the patient should be hospitalized as soon as possible and referred to a psychiatrist. Patients with less severe types of disturbance may not require, and, in some cases, would be more disturbed by psychoanalysis. In some instances the physician has a choice of psychoanalysis or psychotherapy. Obviously, psychoanalysis would be more suitable for individuals with certain kinds of neuroses. It is generally believed that younger, more intelligent patients, with acute discomfort from neuroses, have the better chance for successful treatment and amelioration.

Since a neurosis is a defense that helps the patient remain unaware of

What is PSYCHOANALYSIS?

conflict, there may be no outward symptoms, or the symptoms may not be indicative of the unconscious determinants. Often, the patient seemingly functions well, and the only manifestation of disturbance may be the discrepancy between actual and potential achievement.

Manifestations that are more readily identifiable are recurrent illness that has no organic basis; excessive emotional responses to external conditions, such as anxiety, worry, depression, temper outbursts; and phobic reactions. More difficult to detect are disturbances in human relationships, such as inability to get along with others; generalized feelings of dissatisfaction; and compulsive attitudes that have come to be interpreted, by the patient, as virtues.

Psychoanalytic techniques are less efficacious among patients with personality disorders, such as alcoholism and drug addiction superimposed upon depression or paranoid tendencies. Obsessional neuroses, severe cases of phobia formation or conversion hysteria, and certain cases of sexual perversion, such as fetishism and homosexuality are also considered less accessible to correction through psychoanalytic treatment.

There are certain practical considerations which the physician must consider before recommending psychoanalysis. Among these are the patient's ability to pay for treatment and the amount of time involved. While it is impossible to predict exactly, the period of analysis usually averages from two to three years. Another factor to be considered is the distance from medical centers in which such therapy could be arranged. Other considerations involve the patient's fears about psychoanalysis, most of which can be allayed by simple explanation of purpose.

Perhaps the most important factor to be considered in psychoanalytic treatment is the patient's motivation. If the patient cannot accept his problems as being of psychogenic origin, and is unwilling to recognize his responsibility and exert himself in his own behalf, the prognosis is poor.

A physician may be consulted by a patient who is eager to undertake psychoanalysis for unrecognized reasons. Some of the more common motivations, as noted by Horney, are: 1) a compulsive need for power and influence; 2) a conscious or unconscious need to punish or humiliate family or friends; 3) expectation of the miracle of cure by submission, thus gaining a reward without any real effort; 4) an attempt to become independent of family, using the analyst as an ally in his defiance; 5) an attempt to enter into a bargain with the psychoanalyst, against whom he will later make unconscious claims. Other common motives may result from unconscious neurotic need for an advisor, or father confessor to absolve guilt, or as a license to further self indulgence or self-pity.

The physician who keeps in mind all the components of psychoanalysis, its aims and methods, indications and contraindications, and the patient's basic motivations, could profitably remember Alexander's words:

"Neurosis indeed is the characteristic disturbance of our age as were infections and plagues in past periods when people began to congregate in large cities before they knew how to master the biological hazards of such close coexistence. Psychoanalysis fulfills the same function today that bacteriology did in the past."

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QUESTION: What can be done to avert psychologic distress in pediatric gynecologic surgery?

ANSWER: If the child is less than six years old any operative procedure will usually cause great distress, primarily because the purpose is not understandable at that age. The child who is six or older has better insight and understanding but is also more conscious of psychosexual implications. According to Ball, " . . . it is almost impossible for a child to undergo operations on the genitalia, regardless of the time selected, without some emotional sequelae." In order to lessen the emotional impact, preparation should be given by the mother in accordance with the physician's instruction. Explanation with intensive reassurance is preferable to detailed description. At no time should any person employ the prospect of operation to enforce discipline. The parents of a child who is to have gynecologic surgery should be aware of the castration anxiety inherent in the process of psychosexual development, and of the implicit threat in operative procedures to a child. The patient may regard the operation as punishment for masturbation or for sexual fantasies, and should be told that the operation will correct the difficulty but will not make her different from other little girls. If, in fact, the procedure will result in mutilation, the problem is more difficult. However, deception should be avoided and emphasis placed upon the benefit the child may expect.

Ball, T. L.: Pediatric and Gynecologic Surgery, S. Clin. North America **37**:501 (April) 1957.

QUESTION: When may palliative therapy suffice for patients with borderline psychoses?

ANSWER: Many borderline psychotic patients can maintain adequate behavior with supportive therapy, periodic opportunities for ventilation, and the understanding of the family physician. Palliative procedures should not be devaluated if sufficient adjustment is achieved by them. For example, a physician expressed discouragement because, after 20 years of treatment, his patient still complained of gastric deterioration, and that people talked about her. However, during the 20-year period the

questions and answers

patient had reared her children, had accepted the death of her mother, and had sustained an extensive operative procedure without further emotional disturbance. Obviously, the need for psychiatric referral may become apparent. Among the criteria cited by Miller for determination of this need are acute onset of psychotic symptoms, or progressive inadequacy in adjustment; uncertain diagnosis; no relief from symptoms, or evidence of negative feelings toward the physician; and physician's dissatisfaction with treatment results.

Miller, M. H.: The Borderline Psychotic Patient, Ann. Int. Med. **46**:736 (April) 1957.

QUESTION: Are detailed explanations of disorder actually helpful to the patient?

ANSWER: According to Pratt and others, many physicians underestimate patients' ability to comprehend and to discuss their disorders. Although patients receive practical explanations of tests and treatments, less information is given them about the disease entity, etiology, or prognosis. In an out-patient clinic studied by these investigators 81 of 89 physicians apparently underestimated the patients' level of understanding, and, as a result, provided only minimal information. The patients, in turn, reacted dully to such limited, isolated facts as were disclosed. In this manner, a cycle was perpetuated. The patients' lack of receptivity seemed to be confirmed, and the policy of avoidance of discussion was reinforced. However, Pratt observed that when a physician effectively phrased his knowledge in terms understandable to the patient, response and discussion were possible and the patients evidenced greater interest in the plans for therapy. Pratt also noted from interviews that although most patients expressed a wish for more knowledge, they were hesitant to ask the physician, and had not thought that it was his responsibility to provide them with information.

APHA Conference Report: Physicians' Views Influence Relationship with Patients, Pub. Health Rep. **72**:259 (March) 1957.

QUESTION: Are emotional factors determinant in habitual spontaneous abortion?

ANSWER: In 1954, a clinic was established at the New York Lying-In Hospital for psychiatric observation of patients who had had three or more consecutive spontaneous abortions without evidence of organic disorder. The therapeutic program included initial gynecologic studies and subsequent supportive psychotherapy. Individual physician-patient interviews were utilized to induce confidence and self-assurance. Emotional immaturity, incomplete psychosexual development, intense maternal dependency, inadequate father-daughter relationship, and personality changes immediately before abortion were commonly discovered in 39 patient studies. Although some of the patients had previously aborted in the first trimester, during this study none aborted before the second trimester. Emotional distress seemed to be heightened by initial awareness of fetal movement, and, at this time, patients became less receptive, and complained of headache, fatigue, or malaise. Since paternal inadequacy was regarded as a causative factor in most of these cases, the therapists' reassurance and encouragement were significant as therapeutic measures. The number of abortions in this group was reduced from 92.9 per cent before treatment to 20.5 per cent.

Mann, E. C.: The Role of Emotional Determinants in Habitual Abortion, S. Clin. North America **37**:447 (April) 1957.

The Stubborn Child

● Both parents and physicians may find it difficult to differentiate stubbornness from the contrariness and negativism common in children. Analysis of the situation is confused by the factors of age, environment, and personality. Long-established routines and regulations are challenged, and a child may demonstrate a complete reversal of attitude. Such authorities on child behavior as Ilg, Ames, Gesell, Spock, and Baruch agree that intensified resistance to authority is normal at certain stages of the child's growth.

Parents, with a suggestible child who has suddenly become obstinate, are often bewildered and hostile. Sometimes, they recognize that the abrupt change is caused by mental or emotional disturbance. Sometimes they fear that their authority is challenged, and adopt disciplinary measures. Since the small child's understanding of the reasons for parental demands and punishment is vague he also reacts with hostility. The child may become openly rebellious, or, if he is docile and submissive by nature, may show resentment in such other ways as refusal of food, sleeplessness, or clinging to a bottle. These manifestations, in turn, are the source of more conflict, create more tension, and the stubbornness is thus intensified and reinforced. If continued into adult life, stubbornness may seriously interfere with marital or social harmony. Some individuals may even find criminal acts necessary to demonstrate their particular defiance of authority.

Etiology

Usually between the ages of two and three, a child begins to develop conscious responses instead of reflex and conditioned responses. Zuger described the period from this age to approximately eighteen years as the time when the individual is developing his own concept of self. In the attempt to achieve self-possession and control of his own actions, the child must integrate normal physical changes as well as emotional experiences into this self-concept. Even as he tries to gratify his desires, affection and acceptance are necessary to him. The conflict between these needs is present all through life, but is significant during this period.

Ordinarily, obstinacy is accentuated at about the ages of two and a half, six, eleven, and fifteen years. After each such period the child normally begins a stage of greater stability and responsibility. Definite and repeated phases of behavior can be recognized and expected.

Apparently, in these periods of negativism there is also an imperative urge toward self-expression. In this respect, stubbornness can be interpreted as an attempt at independence. Yet, even as the child resists and defies his parents, he still expects control and authority. Limits against which he can rebel are both necessary and reassuring to him. For ex-

ample, older children may boast to contemporaries of the same restrictions about which they complain to their parents. Strong feelings of dependency coexist with the equally strong desire for independence.

Contributing factors

Other factors besides age may affect a child's performance of such activities as getting up, dressing, eating, care of clothes, elimination, going to school, and play. In a study of 100 children, aged five to seven, made by the Department of Pediatrics of the Albany Medical College, the children without siblings and oldest children showed a higher percentage of negative characteristics than middle or youngest children in a family. In contrast, middle children exhibited a conspicuously higher number of positive characteristics, but they also showed a decided increase in nightmares. The socioeconomic status apparently is an influential factor, since the incidence of negative traits increases in children of the higher income families.

Problems specific to the child's age also affect stubbornness. At two and a half, and, again, around six years, a child is constantly frustrated by his physical inabilities. He does not have the coordination and dexterity to emulate the physical prowess of older children. Hunger, fatigue, and overstimulation also frequently aggravate obstinacy and, in small children, may cause temper tantrums.

The adolescent expresses rebellion with sullenness or evasion instead of tantrums. Physiological changes of puberty, wider social experiences, and greater abilities and skills reinforce the adolescent's drive toward independence. Attempts to satisfy opposing familial and personal demands leave him confused and dissatisfied. Although it may not be apparent, the need for affection and approval is strong at these times of conflict. A sensitive child may become so anxious and conscientious in his efforts to please that, in time, the feeling becomes compulsive. Conformity may become embarrassing to him, but if disapproval seems worse, he may suddenly resort to withdrawal. Another type of child disguises fear of rejection with hostility toward society and parents. In some instances, an overprotective parent may cause resentment in a child with an innately strong will. This is true of the mother whose fearfulness for the child's safety causes her to forbid such activities as bicycling, swimming, and roller skating. The child with a creative nature who likes to draw, build, or read may feel that his likes and abilities are discounted by parents who value physical or social activity. A child consistently expected to perform beyond his years may be able to fulfill specific parental demands but will show stubbornness in other ways. Ilg and Ames explain that certain children find it excessively difficult to make such necessary transitions as from sleeping to waking, to new foods, or from one type of activity to another. Such children are errone-

ously described as stubborn. Actually, they need help in making transitions.

Resentments and negativism are undoubtedly reinforced by demands which are beyond the individual capacity. Too many restrictions, insistence on implicit and immediate obedience, or expecting adult ethical behavior may result in resistance or, at the least, evasion.

Physical manifestations

Ilg describes thumbsucking, temper tantrums, head banging, and masturbation as tensional outlets. Such mannerisms as these are often intensified during periods of excessive stubbornness and rebellion.

Parents are counselled to take a relaxed attitude, as undue attention may encourage the child to construe such a misdemeanor as a weapon. An understanding attitude by parents toward these manifestations helps to decrease tension and, therefore, is more successful as treatment than either severity or rewards. Parents might profitably examine the existing emotional situation to determine if there are undue pressures. The physician who knows the home situation and the personality of the parents can sometimes be of assistance in objective appraisal.

In many instances, regulations of activity can be adjusted without detriment to health, safety, and the protection of society. A teenager who is under legal age cannot be permitted to drive, but he can be permitted some latitude in choice of haircuts and clothes valued by his social group. Toddlers cannot be allowed to destroy valuable property, but fragile art objects can be removed from their reach. Freedom to explore and experiment is necessarily limited by ability to accept responsibility. Frustrations and resentments are, of course inevitable. Baruch advocates that contrary children be encouraged to express their objections in allowable ways even though actions must be controlled. Hostility may be vocalized, for example, and other means of expression, such as writing, drawing, or hammering, permitted, to convert negative attitudes to positive.

Stubbornness and negativism are considered good potentials for social adjustment. They indicate sensitivity to other people and a desire for independence, while submissiveness is often accompanied by apathy and dullness. Understanding of the normal causes of stubbornness, the necessity, and, even, the desirability of such an attitude can be an important aid in prevention of much unhappiness for both parents and children.

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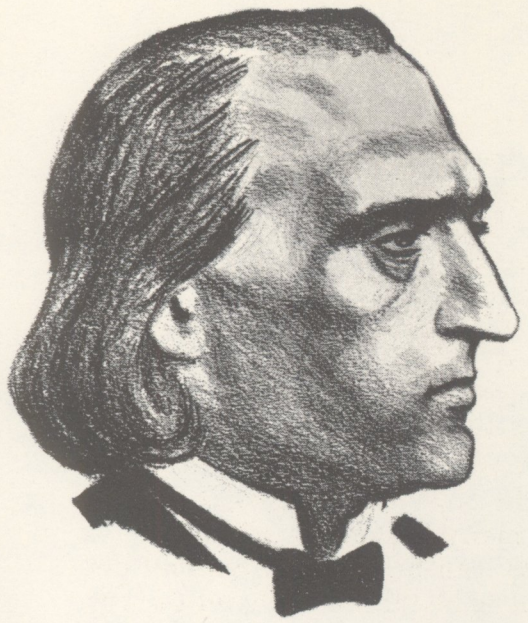

Charcot

TWO YEARS AGO THE FIRST complete biography of Jean-Martin Charcot (1825-1893) was published in Paris by Prof. Georges Guillain. Thus, belatedly, there is afforded adequate appraisal of the man chosen in 1882, to occupy at the Paris Faculte de Medecin, the first chair of clinical neurology to be created in the world. An accolade was also bestowed upon Charcot at his death by a former pupil who, as a young neuropathologist on a traveling fellowship, had journeyed from Vienna to Paris to assimilate whatever the master-lecturer at the Salpetriere had to teach. This eager pupil—"applying himself with full faith and industry"—was Sigmund Freud. Even though Freud admitted his later dissent from some of his erstwhile instructor's theories, he yet felt constrained to say that Jean-Martin Charcot's fame "will always be above opinions and time."

The focus upon Charcot in the 1880's was caused by his scientific approach to the study of hypnosis. At the time of Freud's study at the Salpetriere clinics and lectures, Charcot was mainly occupied in demonstrating that the manifestations of hysteria could be evoked in hypnotized patients. He had arrested the attention of the medical world by receiving, in 1882, the approbation of the French Academie des Sciences for his summation of the clinical limits of hypnosis, thereby ending a sixty-year-old taboo which the Academie had imposed on this subject.

It was a real tour de force to make the Academie, which three times since 1770 had condemned "animal magnetism," finally accept a long description, such as Charcot's paper on Feb. 13, 1882, of absolutely analogous phenomena. It may be recalled that in 1784 the disciples of Mesmer who were influential in court circles had insisted that the Academie appoint a committee to investigate Mesmer's so-called "magnetic fluid." This group had included among its personnel the then American Ambassador, Benjamin Franklin. The committee returned a sternly unfavorable report, which put Mesmer into retirement and outlawed "magnetism" as a subject worth the Academie's attention.

By the mid-nineteenth century there existed a somewhat more congenial mental climate for discussion of the topic. James Braid of England in 1843, to avoid the charge of "mesmerism" about his own experiments, coined the term *hypnotism.* Azam had written of Braid's findings in the *Archives de Medecine* in 1859, and Broca spoke upon the subject before the Academie des Sciences one year later. According to Bromberg, it still remained for Charcot and his students to establish hypnosis as an accepted medical technique.

Charcot's authority was well-grounded. His earlier achievements in general pathological research had included: in 1853, a clinical description of chronic rheumatism; in 1863, studies of the kidneys and joints in patients with gout; observations on pain and paralysis in metatastic cancer; explanation of the pathogenesis of cerebral hemorrhage; differentiation between Parkinson's disease and multiple sclerosis; and "the first clear delineation of the principles of cerebral and spinal localization of lesions." Guillain further notes that his work on amyotrophic lateral sclerosis was "of epic proportions."

By 1875, Charcot, according to Bromberg, had "literally carved a clinical science of neurology from the motley group of syphilitics, chronic invalids, and paralytics that thronged the halls of the Salpetriere." The reward of his tireless labors, from 1875 onward, was the acceptance of his dissertation before the Academie.

Two later writings of Charcot's are of especial interest. Just before his death he published in the *Nouvelle Iconographie* and in the *Revue Hebdomadaire* an article entitled "Le foi qui guerit." In the article he stated his well-reasoned conclusions as to the mental state most favorable to faith healing. Cautiously, he agreed with Shakespeare that "there are more things in heaven and earth than are dreamt of in your philosophy." The other late work was a study of "Les Demoniaques dans l'Art," with Recher, in 1887.

Guillain's biography furnishes a portrait of Charcot, the man, as well as of Charcot, the scientist. He was the son of a well-to-do Parisian carriage-maker. In his early youth he wavered in choice of career between medicine and art. He became a first-rate caricaturist, made many sketches of his own Barrymore-like profile, and also enjoyed painting on china and enamel. He was a regular visitor to museums, an ardent listener to music, and an omnivorous reader. He kept aloof from politics, but enjoyed the company of Gambetta and entertained other political figures as well as scientists, artists, and visiting physicians at his home on the boulevard Saint-Germain. As a renowned consultant, his later years involved frequent travel from one European capital to another. He drove both himself and his students at an unsparing pace which, according to his biographer, probably led to his sudden death. He was fatally stricken on August 16, 1893, at the age of 68, while on an excursion with two of his former students from Paris to Morvan. The diagnosis was then given as acute pulmonary edema.

According to Guillain, in Charcot's address upon his election to the Academie des Sciences in 1883, he said, "I believe that medical practice has no real autonomy, it lives by borrowing, by application; that without incessant scientific renewal, it becomes an obsolete routine." Such was the philosophy, in fact, which Jean-Martin Charcot constantly applied to his own productive life.

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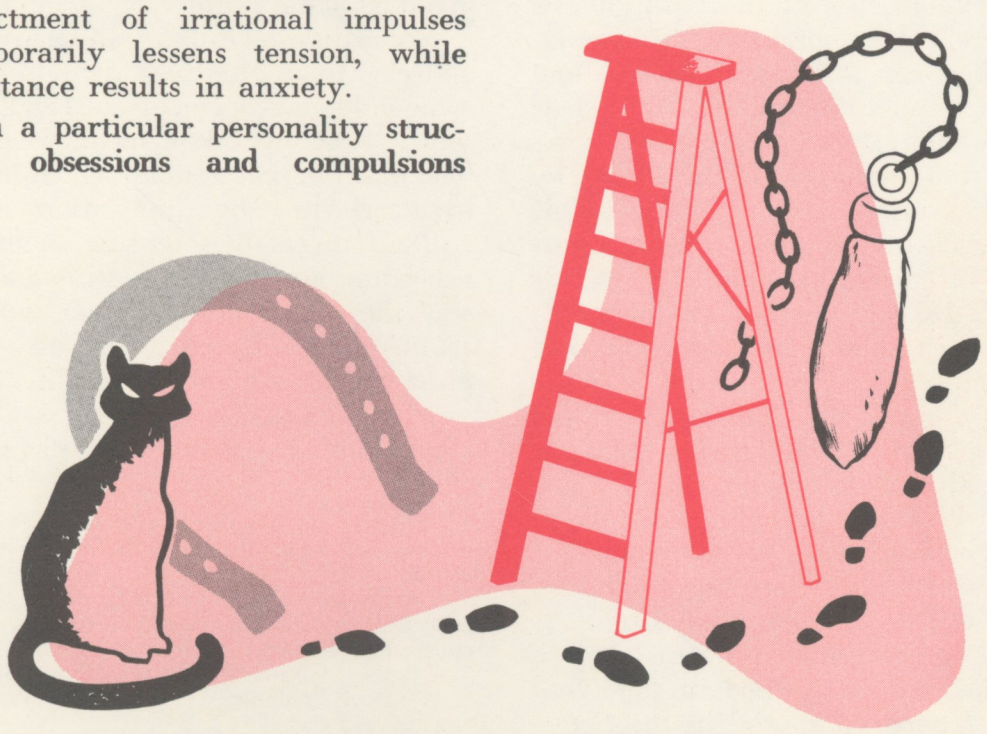
Obsessive-Compulsive Neurosis

OBSESSIVE-COMPULSIVE neuroses are defined by Laughlin as "emotional patterns of reaction in which the prominent clinical feature is the intrusion of insistent, repetitive, and unwanted ideas, or unwelcome impulses to action." The familiar experience of being unable to put a melody out of mind, or the childhood game of stepping between cracks in the sidewalk is an example of mildly obsessive and compulsive activity. In moderation, such patterns cause little disturbance. Severe obsessive-compulsive neuroses, however, may be incapacitating as well as distressing with direct effects upon daily activities. Obsessive thoughts may consist of doubts, wishes, fears, prohibitions, or admonitions that have unconscious emotional significance. Although such thoughts are usually repugnant to the individual, they are actually an unconscious substitution for repressed ideas that are even less acceptable. When these repressed thoughts become conscious, obsessions develop as a defense against them. Obsessive thinking, therefore, is a protective mechanism developed in response to psychologic need. Compulsions to perform acts contrary to individual social standards or conscious wishes are similarly intended as defense mechanisms. Enactment of irrational impulses temporarily lessens tension, while resistance results in anxiety.

In a particular personality structure obsessions and compulsions usually occur together. Neurosis is most likely to develop in the person with an obsessive personality when defense patterns are overdeveloped. Traits which are considered characteristic of the obsessive person include obstinacy, procrastination, indecision, miserliness, meticulousness, orderliness, overconscientiousness, rigidity, persistence, and love of symmetry. In many occupations, persistence, precision, and orderliness are desirable. For example, this is true of occupations that require detailed craftsmanship or intricate bookkeeping. In the obsessive personality, however, exaggerated traits often result in time and effort wasted on unimportant details.

The obsessive individual prefers an orderly and predictable life. He tends to set a high standard of performance and drives himself to maintain it. Rigid interpretation of values makes the occasional advantage of compromise difficult for the obsessive individual to accept. Manifestations of indecision, doubt, procrastination, and pessimism are also familiar forms of defense. Pessimism allows such patients effectively to guard themselves against unpleasant surprises. They are unable to modify this reaction even when they realize that this defense actually entails greater anxiety for a longer period.



Persons with obsessive personalities often possess superior intelligence. Such obsessive traits as thoroughness and exactness should be assets in intellectual endeavor. The additional characteristic of striving for high personal standards may also contribute to improved performance on intelligence tests. Actually, some authors have suggested that superior scores on intelligence tests could be directly related to character factors.

Paradoxically, superstitiousness is also frequent in obsessive persons. An impulse to throw salt over the left shoulder or to wait for a lucky day is a manifestation of obsession.

Dynamics

The characteristics of the obsessive individual are developed primarily as defenses against anxiety. Defense patterns seemingly lessen the awareness of anxiety-producing situations. If obsessional traits adequately serve this purpose, personality adjustment is maintained. If, however, defenses become inadequate, overdevelopment occurs in times of emotional stress.

Deprivation of love and affection, whether real or imagined, is always a factor in the early development of obsessional traits. The need for love in childhood may result in inability to express genuine affection in adult life. Limited emotional capacity may develop as a defense against repeated rejection. Any affection offered by the individual is usually motivated by feelings of guilt or by the belief that unselfish activity is required of him for acceptance.

Close personal relationships are particularly threatening to the obsessive person. Because he lacks self-esteem, he attempts, in defense, to give the impression of being aloof, reserved, conscientious, intellectual, serious, and preoccupied.

Many defensive traits may be correlated with parent-child relationships. Adult stubbornness and par-

simoniousness may be related to the struggle for power between parent and child during the child's early bowel training. Preoccupation with anal function may be suppressed at this stage, particularly if the parent expresses disgust. This preoccupation may be reactivated in later life, through symbolic expression.

If the parent overemphasizes control, performance, independence, maturity, orderliness, and the abandonment of childishness in early childhood, the patient may develop inhibitions which limit spontaneous expression. However, confusion and resentment may result from parental over-indulgence, and, as a result, hostility may be accumulated and repressed. To the child, any outward expression of hostility to the parental figure jeopardizes security, and he fears his destructive impulses. For him it is possible that, through some magic, they may become fact, and his source of love, warmth, and food would then be denied. As a result, intolerable impulses must be disowned. The obsessive patient may unconsciously employ one of several substitutions in repression and displacement of hostile emotions. Isolation, projection, rationalization, repression, symbolization, and undoing are the more common mental mechanisms. For example, isolation may be employed whereby the emotional significance of an event is displaced. Thus, the patient is able to recall an event without emotion, even if it is blasphemous, murderous, or incestuous. The emotional component is experienced in another context. If rationalization is used, the individual unconsciously attempts to justify his behavior or motives. By repression, the patient may succeed in suppressing an emotion. Undoing consists of two actions of which the second must be the reverse of the first. For example, a patient may need to lock and then unlock a door. Thus he undoes or atones for the first act.

If the stress to which the patient is subject is not sudden, a gradual accumulation of obsessive traits may suffice for adequate adjustment. Obsessive neurosis develops in sudden stress, when these mental mechanisms become inadequate and when repressed impulses impinge upon consciousness. The onset of obsessions serves to reinforce repression by directing attention away from the more immediate problem.

Treatment

Diagnosis of pathologically obsessive personalities must often be made on the basis of 1) the number of obsessive defensive patterns, 2) degree of development, and 3) degree of personal and social handicap. The patient rarely seeks medical help for obsessional defenses. The responsibility of the physician, therefore, is to recognize and evaluate these symptoms and prepare the patient for psychiatric referral. Some caution must be maintained in the method of suggesting therapy because of the obstinacy of obsessive individuals. In a case cited by Laughlin, a 38-year-old business man had been referred by his physician because of difficulties with his work and his family. The patient was somewhat hypochondriacal and was of a rigid and meticulous type of personality. Over-concern with detail had become detrimental to his efficiency and to his self-respect. Actually, on character analysis, it was apparent that his indecision and ambivalence were comparable to the attitudes of his parents who had been alternately permissive and strict. In this particular character neurosis the patient's defensive activities had, for awhile, contributed to his success, but when overdeveloped they had become stultifying, both professionally and emotionally. During therapy the patient became aware of his obsessive traits and could recognize his own hostility. With increased self-tolerance he became kinder in his human relationships, so that although therapy was necessarily protracted, it was, in this instance, worthwhile.

Treatment of these individuals is never easy. Defensive patterns are not easily surrendered, and new patterns must be developed to replace the handicapping ones. The patient may have so little positive desire to cooperate with the therapist that he defeats all efforts. Resistance to change and to accept new ideas also makes therapeutic procedures difficult and, necessarily, slow.

Valuable reassurance may be given by the physician by telling the patient that his illness is neither uncommon nor indicative of insanity. In mild cases this is often enough to afford relief of symptoms. Although simple explanation is not curative, it is justified when psychotherapy is not possible because of limited time and money, or the absence of adequately trained therapists.

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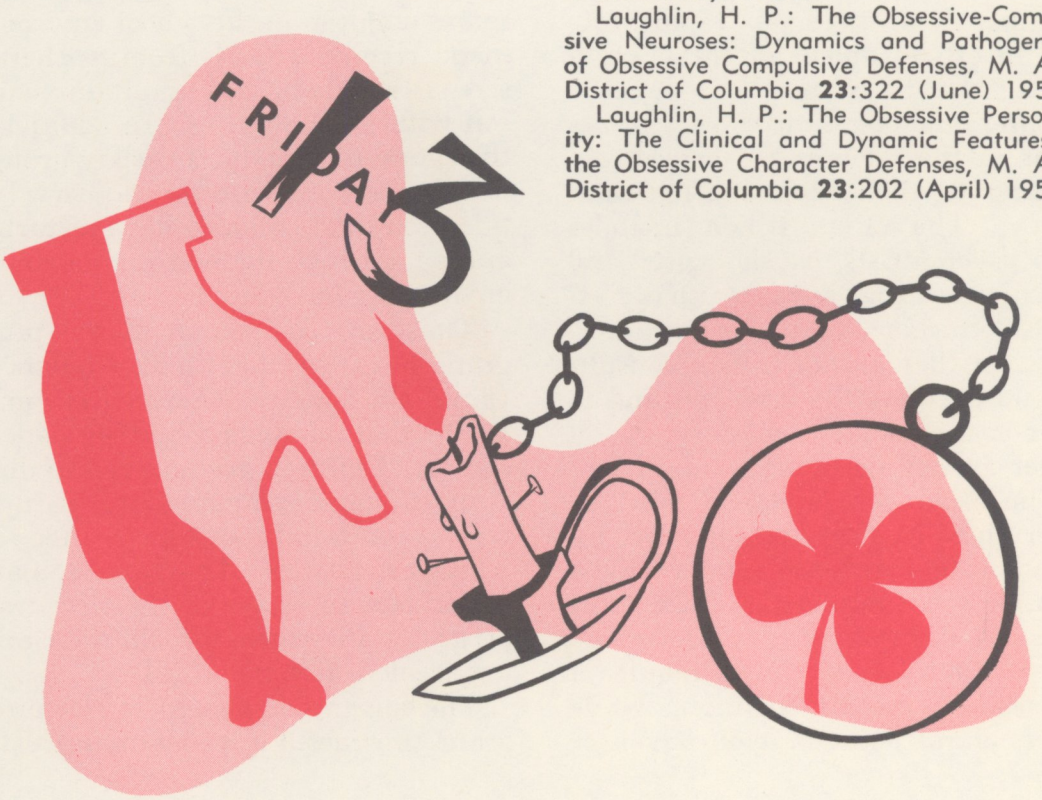

CHILD GUIDANCE CLINICS

In 1909, Healy founded the Juvenile Psychopathic Clinic which later became the Illinois Institute for Juvenile Research under the direction of Adler. Although the services were designed primarily for delinquent children, this clinic is generally regarded as the beginning of the child guidance program. Approximately 15 to 20 years elapsed, however, before child guidance clinics were established throughout the country. During this period, children with emotional disturbances were treated by changing their total environments; they were sent to orphanages, correctional institutions, or hospitals. The practice of treating a child in his own surroundings developed later.

In 1921, the administrators of the Commonwealth Fund, established in 1918 for medical education, experimental health services, and medical research, provided for a "Program on the Prevention of Delinquency." In this program the community's responsibility was emphasized, as well as the need for co-ordination of various disciplines, and, particularly, the need for assistance from psychiatrists. During the next five years The National Committee for Mental Hygiene established several demonstration child guidance clinics, under the direction of Lowrey. From this beginning, then, there was rapid progress in establishment of such clinics throughout the country.

Child guidance centers vary somewhat in the services performed, according to their size, staffing, and policy. The clinic which includes staff psychiatrists, psychologists, and psychiatric social workers usually affords both short-, and long-term therapy. Smaller clinics utilize consultants to evaluate the problems and to refer patients, if necessary, to a larger agency or to a psychiatrist.

The need for guidance may be determined by the child's parents, by school authorities, the family physician, or court authorities. The basis for acceptance of patients also varies. For example, some clinics require a physician's recommendation, while others admit patients upon school or court recommendation, or simply at the parents' request.

Usually, the initial procedure is interview of the parents and child by a psychiatrist and social worker. A psychologist then gives the patient intelligence, aptitude, and personality tests. Evaluation of the environment may be made after home visits by a social worker. The treatment required is determined by study of the combined reports of the three investigators, and their evaluations of the nature, origin, and severity of the child's disturbance.

For example, the St. Louis County Health Department in Clayton, Missouri, has a community health program which is divided into four components. The purpose of the departments is provision of care according to degrees of disturbance in children. The first division is the Lay Educational Services program which is designed to help parents by group discussions and workshops, in which films and plays are used. Children whose parents would be referred to this group are those with minimal symptoms, developed as a result of environmental stress.

The second component of the program is called the School-Centered Services, in which a psychiatric social worker or a clinical psychologist observes children in the school environment, receives reports from teachers, screens referrals, and maintains liaison with other services. In addition, the counsellor conducts weekly group therapy sessions with the mothers. In this group the children have disturbances for which there are no obvious environmental causes.

The third component of the program is called the Child Guidance Clinic, the function of which is similar to that of other child guidance centers. Children are referred to this clinic if their symptoms are disruptive to the family and have affected school attendance. The parents may participate in either of the first two programs in which the children are not treated directly at all.

The fourth component of the program provides for residential treatment of patients on a 24-hour basis. The patients are children with disturbances severe enough to have disrupted school attendance. In such cases the family environment precludes effective treatment at home.

The organization of this program illustrates the increased importance that is now accorded the education of parents. The child's need for love and recognition as an individual has been emphasized since investigators first began to study the effects of emotional deprivation. The fact that many parents fail to provide appropriate emotional support is obvious from the reportedly large number of disturbed children. One suggested reason for this failure is lack of parental self-confidence. Parents have been confused by conflicting recommendations of permissiveness and discipline. As a result, many need further education in child care and also what constitutes normal variability in child behavior. With such knowledge, parents would be enabled to recognize early deviant manifestations. Frequently, the length of time and amount of therapy required to resolve a child's disturbance are contingent upon the duration of the disorder; therefore, parents should be informed of the assistance that is available to them in child guidance clinics.

Suggested Reading

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The Passive-Dependent Personality

In the diagnostic manual published in 1952 by the American Psychiatric Association, the passive-dependent personality is listed as one of three subdivisions in the diagnosis of passive-aggressive personality. An infantile stage of emotional development is the basis of these personality disorders. The passive-dependent patient is differentiated from the passive-aggressive or aggressive patient by his marked absence of hostility expression and his compliance. Tearfulness and helplessness characterize his behavior. Stubbornness, procrastination, pouting, irritability, temper tantrums, and destructive behavior are manifestations of the passive-aggressive or aggressive personality. The neurotic patterns manifested in all of these personality types do not assume the proportions of clinically recognizable psychosis or neurosis. The main individual problem is that of a poorly integrated personality, unable to tolerate the situational and environmental stresses of adult life.

In one study of 400 patients with personality disorders 92 were classified as having passive-dependent personalities. This was the largest number of patients in any one category. Most of these patients were between the ages of 21 and 30 and there were more women than men, although men were predominant in the generic group. No similarities in occupational or social backgrounds were found in the patients' histories.

Development of passive-dependent personality

A combination of unfulfilled dependency needs during infancy and parental overprotection and domination during childhood may result in development of the passive-dependent personality. Denial of early physical and emotional needs results in anxiety and fear of rejection in the child. As he grows, he accepts protectiveness and domination as the means of obtaining attention and approval. He carefully represses all feelings of hostility, because he fears that any expression of these emotions will result in total rejection. He, then, becomes accustomed to compliance, and, therefore, dependent on authoritative figures.

The passive-dependent patient is often described as being good and happy during childhood. Usually he is a good student. If he has a sympathetic supervisor, he may achieve a reasonable occupational success in a subordinate position. Many patients with this temperament do not marry, because of emotional closeness to parents, or because of an underlying fear of sexual inadequacy. If they do marry, the sexual relationship is often unsatisfactory. However, a passive-dependent individual may make a neurotic but workable adjustment to adult life. Difficulties become apparent when he is subjected to strain to which he is not emotionally equal. Sometimes such patients regress to a state of complete dependency. The exact amount of stress which can be tolerated varies with the individual capacity to adjust and the amount of the residual dependency needs.

Illnesses associated with this personality

Depression and anxiety are frequent reactions in these patients. There is some evidence that these individuals are predisposed to develop depression, and some have suicidal tendencies. Depression may be the result of repression of hostile instincts, or from an inherent feeling of total rejection. Anxiety frequently is manifested in overconcern with health, possibly because of overemphasis by the parents on health during childhood. Other clinical manifestations include phobic and hysteric reactions.

In a case cited by Whitman and associates, the patient was a 30 year old male who became depressed when his brother's family, with whom he had been living, moved away from town. The patient was a photoengraver and was both responsible and extremely efficient. He had been married and divorced, had been in the Army, and had adjusted well to his situation. When his dependency needs were frustrated by this particular change, however, he became restless, helpless, and tearful, although neither resentful nor hostile. This particular depressive reaction was resolved in four therapeutic interviews in a period of two months. The patient's dependence upon his brother and the effect of his attitudes upon his work performance were

clarified, and the more positive traits of his personality were reinforced. In six months he reported improvement and was planning to remarry and to buy a home of his own.

Fatigue, excessive sleeping, and emotional illness are common defenses against stress. The patient is unconsciously trying to find a socially acceptable way of returning to a protected state. He may, also, be attempting to maintain what to him is a satisfactory environment. Hospitalized patients are sometimes reluctant to leave, as the protective atmosphere of the hospital removes the necessity of independent action. Similar reactions have been noted in prison inmates. However, it must be emphasized that the individual patient is unaware of his use of these defenses. Indeed, he will usually resist the idea that his symptoms are the result of emotional problems and not of organic illness.

Physical illnesses developed by passive-dependent patients include peptic or duodenal ulcers, alcoholism, drug addiction, obesity, and anorexia. Investigators have established the predisposition of patients with passive-aggressive personality to ulcer development. Under emotional stress passive-dependent patients may also develop such ailments. Alcoholism, drug addiction, and chronic overeating in these patients result seemingly from the unconscious association of food with dependency satisfactions. To the patient, alcoholism and drug addiction have the added advantage of softening the impact of inner conflicts. Caution is urged in the administration of drugs at any time to the passive-dependent, as the time and amount of medication can never safely be left to his discretion.

Patients with such illnesses as drug addiction, severe anorexia, severe depression and anxiety, or chronic alcoholism require specialized treatment, of course. However, the family physician is frequently asked to treat patients with mild symptomatic illnesses. If the physician can maintain an objective attitude, the patient may benefit from supportive treatment as well as from relief for his symptoms. If the physician shows any annoyance, patients interpret this as rejection. However, they will make insatiable demands on the physician's time and energies if they find him sympathetic. Interpretive treatment should be confined to encouragement of the patient's positive attributes and, perhaps, his expression of hostilities. Exposure of his defenses without substitution or rehabilitation therapy may result unfortunately for the patient. In planning treatment, the physician should be mindful of his own abilities, the amount of time he can give, and the patient's level of emotional maturity and insight.

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Book Reviews

EMOTIONAL ILLNESS: HOW FAMILIES CAN HELP. *By Karl R. Beutner, M.D. and Nathan G. Hale, Jr. M.A. Pp. 158. Price $2.75. New York, G. P. Putnam's Sons, 1957.*

● The plan of this volume is to afford assistance for families of mentally ill patients in adjustment to problems intrinsic to such illness. Practical advice on familial relationships is not easy to formulate, and this book should help to explain some of the more confusing and disturbing situations that arise in management of the emotionally ill. The material is presented in non-technical language from the viewpoint of the relatives of any patient with emotional disorder. There is a short reading list appended, and a foreword by Karl M. Bowman, M.D.

A PSYCHIATRIC GLOSSARY: THE MEANING OF WORDS MOST FREQUENTLY USED IN PSYCHIATRY. *By the Committee on Public Information, American Psychiatric Association. Pp. 48. Price $1. New York, Mental Health Materials Center, Inc., 1957.*

● This publication was prepared for clarification of some of the terminology in psychiatry and to explain technical expressions that are frequently misunderstood. H. P. Laughlin, M.D., made the initial selection of words, expressions, and proper names. The volume is not intended for diagnostic usage and is directed mainly to non-psychiatrists. Neurological terms are not included in the selection of more than 500 definitions. Obviously no group of persons would ever be wholly in agreement as to which expressions most need standardization and definition. Nevertheless, the GLOSSARY should be an extremely useful compendium, and certainly it affords much information in compact and simple fashion.

BOOKS RECEIVED

HALSTED OF JOHNS HOPKINS, THE MAN AND HIS MEN. *By S. J. Crowe, M.D. Pp. 247. Price $5. Springfield, Charles C Thomas, 1957.*

THE INVESTIGATION OF DEATH. *By D. K. Merkeley, M.D., Med. Sc. D. Pp. 138. Price $4.50. Springfield, Charles C Thomas, 1957.*

WHAT ARE THE FACTS ABOUT MENTAL ILLNESS? *By the National Committee Against Mental Illness, Inc. Pp. 44. Washington, The Committee, 1957.*

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Kinross-Wright, V.: M. Clin. North America *41*:295 (Mar.) 1957.

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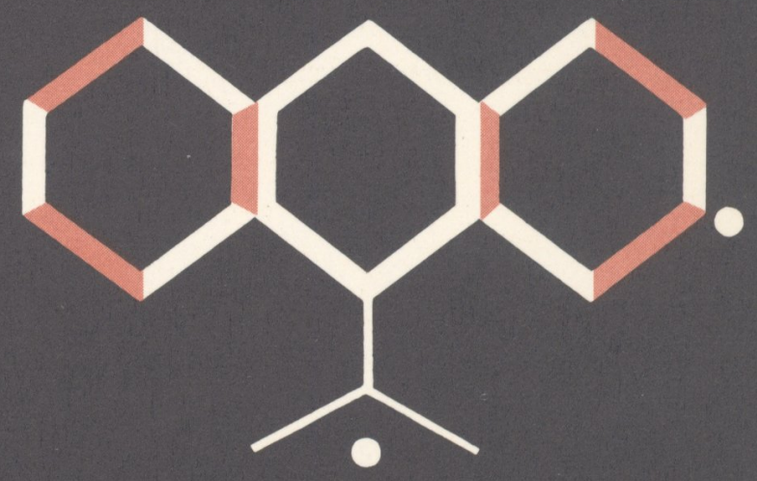

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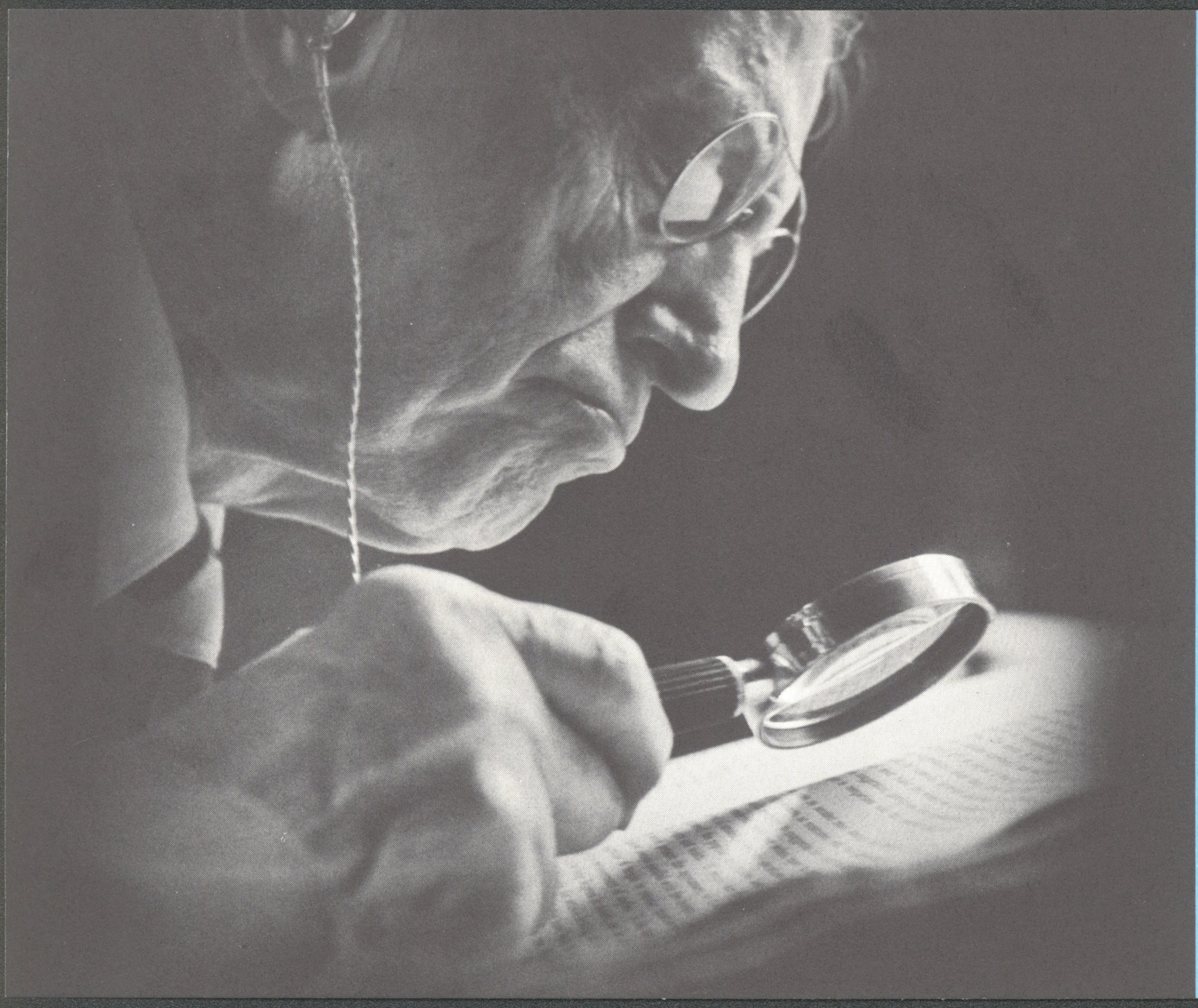

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THE OEDIPUS COMPLEX

Development and Resolution in the Normal Male

The infant's first attitudes are exclusively narcissistic ones, in which gratification of biological needs is predominant. Shortly, however, the mother is recognized as a separate person who satisfies hunger and provides comfort. The infant transfers some of the primary narcissism to the mother, and develops a need for constant attention.

Between the ages of two and one-half to four years, the child recognizes the father as a competitor whom he wishes to eliminate. With increasing hostility and aggression, the fantasy of an incestuous relationship with the mother occurs.

From the age of three and one-half to five, ambivalence toward both parents develops. This ambivalence results from the child's realization that he cannot monopolize his mother and from his fear of retaliation and loss of love because of the persistent wish to eradicate the father.

The period of Oedipal resolution begins about the age of five or six. Unacceptable impulses are abandoned or repressed and emulation of the father begins. In time, however, the child develops and maintains only affection toward both parents.

During adolescence, object choice is transferred to a girl as much like the mother-figure as possible, and aggressive energy is expended in competitive rivalry outside the family.

Resolution of the Oedipal complex is requisite for normal psychosexual development. The Oedipal situation is an adaptational or developmental one. Because it is experienced only in fantasy, it cannot be voluntarily recalled. When determination of the origin of emotional disturbance is necessary, the content of the unconscious may be interpreted to the individual by means of psychoanalysis.

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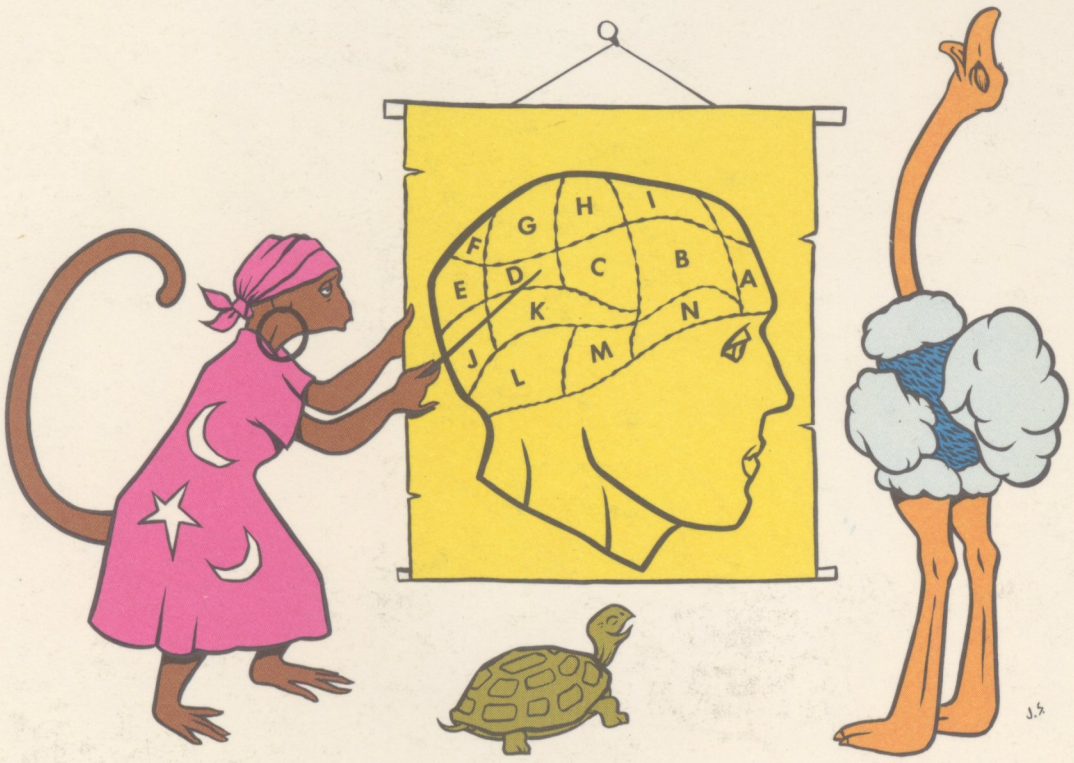

"The mind of man is far from the nature of a clear and equal glass, . . . nay, it is rather like an enchanted glass, full of superstition and imposture."

Bacon.